

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNL1805	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MIAN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 09/15/2011
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - FAIRFIELD GLJ			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SAMARITAN WAY CROSSVILLE, TN 38558		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies Based on the initial survey conducted on 9/15/11, it was determined the facility was in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board of Licensing Health Care Facilities and Chapter 1200-08-06 Standards for Nursing and its referenced publications.		N 002		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

8899

WQ5Y21

If continuation sheet 1 of 1